

State of Michigan
Department of Consumer & Industry Services
Michigan Automated Prescription System (MAPS)
P.O. Box 30202, Lansing, Michigan 48909
Phone: 517/373-1737 Fax: 517/636-6449 Email: Mapsinfo@michigan.gov
REQUEST FOR MAPS REPORT – Practitioner/Pharmacist

Patient's Full Name: _____		
First	M.I.	Last
Address: _____		
City/State/Zip _____		
: _____		
Date of Birth: _____		
SSN or Driver's License Number (if available): _____		
Aliases and Other Addresses (if known): _____		
Report Period Requested From: _____ to _____		
Date Date		

Provide a brief summary of the facts and circumstances under which you are requesting information regarding this patient.

(If you need additional space, please continue on the reverse side of this form.)

Practitioner or Pharmacy Name: _____	
Please Print	
Address: _____	
City/State/Zip _____	
: _____	
MI License	
Number: _____	DEA Number: _____
Telephone Number: _____	FAX Number: _____
Signature: _____	

I certify that this information shall be used for the purpose of providing medical or pharmaceutical treatment to a bona fide current patient. I shall not provide this information to any other person or entity except by order of a court of competent jurisdiction.

For Department of Consumer & Industry Services use only:			
Approved:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Signature _____ Date _____